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ABSTRACT

This paper argues that attempts to prevent non-sanctioned drug use through education have spawned a variety of programs and prescriptions. Sophisticated and ideosyncratic vocabularies have been used to describe the various recommendations. The literature refers to developing self-concept, mental health and decision-making skills. References are made to the communication-persuasion model, induced-cognitive dissonance, confluent education, values education and assertiveness training--all in the name of preventing some vaguely conceived drug problem. The author asserts that virtually every activity with a psychological or educational sound has been offered in such convincing terms that little scrutiny has been made of their premises, potential or educational integrity. The paper focuses on two issues. First, since self-concept development is a prominent feature in current drug education programs, it is argued that these approaches are based on questionable assumptions and erroneous extrapolations. Their validity is therefore in doubt. Second, the issue of educational integrity and ethical responsibility is considered in relation to many prominent approaches to drug education. Hidden beneath the euphemisms, the author claims, are attempts to create compliant behavior through deception and bias. The common attempt to create compliant behavior in these programs is presented as antithetical to education itself. (Author)

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A Skeptical Look at Drug Education

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Drug education has had a controversial history. When society decided it had a drug problem, the demand for immediate measures in education promoted the hurried and often indiscriminate production of programs and materials. One observer (Bland, cited in Cornacchia, Bentel, & Smith, 1973) compared the situation to Leacock's mythical character who "flung himself from the room, flung himself on his horse and rode off in all directions!" (p. 3). The common attitude prevailed that if students were informed of the dangers of non-sanctioned drug use, they would choose not to use them. Reappraisal of these efforts found them wanting and drug education was described as part of the problem rather than part of the solution.

The discredited information approaches have been replaced with a variety of programs and prescriptions for drug education. Sophisticated and idiosyncratic vocabularies have been used to describe the various recommendations. The literature contains references to developing self-concept, mental health, and decision making skills. We see references to the communication-persuasion model, the use of model-reinforcement counselling, induced cognitive dissonance, confluent education, values education, and assertiveness training--all in the name of preventing some vaguely conceived drug problem.

There is somewhat of a contest occurring in the current drug education scene. Researchers and program developers are attempting to discover what sort of learnings, presentations, or experiences will best ensure that students will abstain from using certain

non-sanctioned drugs. Virtually every activity with a psychological or educational sound has been offered in such convincing terms that little scrutiny has been made of their premises, potential, or educational integrity.

My comments today will focus on two major issues in the current drug education literature. First, an examination will be made of the common self-concept development approach in drug education. Following this, the broader issue of educational integrity and ethical responsibility in drug education will be considered.

The Self-Concept Enigma

Self-concept development has become a prominent feature in current drug education programs. Reference to self-concept or other terms with similar meaning[1] is found in programs or prescriptions represented as values clarification (Bensley, 1971; Coronado Unified School District, 1973), confluent education (Strandmark, 1974), developing personal responsibility (Low, 1976), combating failure in schools (Betros, 1974), communications (Kurzman, 1974), or other (National Coordinating Council on Drug Education, 1974; Nelson, 1975; Schaps, Cohen, & Resnik, 1975). Each of these applications make two important assumptions. First, it is assumed that

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[1] Terms such as self-concept, self-image, self-acceptance, self-esteem, feelings toward self have been used with similar meaning in the drug education literature.

poor self-concept is causally related to non-sanctioned drug use or drug abuse and on this basis the preventive strategy is to improve the self-concept. Since the corrective prescriptions have been established for application to undifferentiated student groups, a further assumption is implied. That is, it is assumed that non-medical drug use caused by poor self-concept is sufficiently common to justify application of the corrective procedures to all students. Neither of these assumptions have received careful scrutiny.

A typical statement linking self-concept to drug use can be found in Le Dain (1973). "We see much non-medical use as having its origins in poor self image or lack of self acceptance" (p. 21). Several qualities of this statement should be noted. "Much" implies quantity, "non-medical use" is undifferentiated as to kind, and causation is implied. These elements are found in most references to self-concept development as a preventive strategy. For example, the National Coordinating Council on Drug Education (1974) states that "drug educators have learned that people who abuse drugs often feel unhappy about themselves" (p. 1). Context supplies the assumed causation. Nelson (1975) claims for an Ohio program that "abusive behavior patterns, such as drug abuse, are generally developed by people who do not feel good about themselves" (p. 22). He recommends developing a positive self-concept as one of the most important aspects of a preventive program. A New York State legislative committee (Betros, 1974) reported "the immediate cause of substance

abuse is poor self-concept among the young" (p. 8).

Attempts to empirically verify the assumption that poor self-concept leads to non-medical drug use or drug abuse are met with frustration. Almost all writers allude to evidence in support of the assumption but do not provide reference to the alleged evidence. One prominent program has offered some evidence. The Coronado program (Coronado Unified School District, 1973) claims support from "research within our district and in numerous other schools throughout the nation" (p. 9). But the five research papers referenced (Carney, 1970a, 1970b, 1971a, 1971b, 1971c) originate from the same internal source and require extensive editorial liberty to even vaguely support the claim. Independent appraisals of the studies have questioned their validity on the basis of methodological weakness and a paucity of significant findings (Berberian & Thompson, 1974; Brown, 1977; Goodstadt, 1974; Warner, 1975). No information was given as to the identity of the "numberous other schools throughout the nation." Empirical support beyond the drug education literature is also unavailable. A review of studies which included self-concept measures with non-sanctioned drug users was unable to identify even a nominal relationship between self-concept and non-sanctioned drug use.

Support for the self-concept assumption in drug education cannot be derived either from the drug education literature or the literature relating to drug users in general. Since the meaning

of non-medical use or abuse has been variable and unspecified, the examination of another line of evidence is indicated.

In advocating the self-concept development approach to drug education, Swisher (1974) made the following statement.

> The epidemiological literature on addiction and alcoholism [emphasis added] invariably concludes that negative feelings toward self . . . propel an individual towards a life style characterized by dependency on drugs or alcohol. If these factors are the basic underlying causes of the symptomatic compulsion to use drugs, then it is somewhat logical to conclude that a drug abuse prevention program concerned about the causative factors would attempt to alter these causes. (p. 157)

No references were provided with the statement, however and important difference from the previous statements is to be noted. Negative feelings toward self is attributed to addicted and alcoholic persons. Aside from the causation portion, this may be verified with relative ease in the literature originating primarily from persons who have come to the attention of treatment specialists (that is, clinical cases). A number of years ago, Fort (1969) noted that most generalizations about drug users were obtained from the clinical addict. Poor self-concept has commonly been associated with the clinical addict. But this does not mean that the undifferentiated drug user nor the non-clinical addict suffers from a poor self-concept. In fact, Le Dain (1973) reviewed evidence suggesting that the non-clinical addict does not differ significantly from other people in personality characteristics.

The finding that addicted persons in treatment suffer from poor self-concept is hardly unexpected or revelatory. Clinicians and researchers (eg. Murray & Jacobson, 1971) have repeatedly affirmed that most patients in psychotherapy experiences low self-esteem, regardless of the originating complaint. But this does not necessarily imply causation. It is just as tenable to postulate that the poor self-concept developed concurrently or even resulted from the addiction. The Swisher (1974) quotation clearly refers to poor self-concept causing the drug dependent life style. Statements of rationale for the self-concept development orientations in drug education similarly refer to causation. Even the Le Dain (1973) statement presented earlier clearly assumed causation in contradiction to repeated cautions against doing so later in the same report. Similar contradictory reasoning and twisted logic is found in the New York legislative report (Betros, 1974). The committee accepted the opinion that "poor self esteem was the invariable common denominator of substance abuse" (p. 17) but not recreational experimentation (undefined). It was subsequently noted that raising self-esteem "is an absolute prerequisite to successful rehabilitation" (p. 17) of the person in treatment, and therefore, developing "true self-esteem" (p. 17) is a realistic method of helping people to "bypass substance abuse altogether" (p. 17). Further comment extended this reasoning by assuming "if self-esteem is critical to abstinence" (p. 18) drug use may be prevented

by developing self-esteem. Such reasoning cannot be empirically supported.

In summary, the assumption that poor self-concept causes non-medical drug use cannot be supported. Although correlative evidence exists linking clinical addiction and poor self-concept, it is not possible to determine directionality of cause nor if poor self-concept and addiction develop concurrently. This does not rule out the possibility that some non-sanctioned drug use is due to a defective self-concept. The question is, how much? There is little doubt that the self-concept development approaches can maximally apply to a small proportion of non-sanctioned drug users and even a smaller proportion of students in general. Educationally, the significance of this is that it makes little sense to apply a corrective self-concept program to all students (or an undifferentiated subgroup of students) for the purpose of preventing drug abuse. In no way is this an argument against the value of self-concept development in schools, but rather against the purpose as commonly used in drug education. Since education has become concerned with self-concept development for reasons beyond those professed in drug education, it is even less justifiable to duplicate efforts under the pretext of preventing non-sanctioned drug use (or drug abuse).

Educational Integrity and Ethical Responsibility

Concern for educational integrity and honesty have been over

shadowed by the insistence that drug education must prevent non-sanctioned drug use. This has often resulted in a compromise of the educational process. Several years ago in reference to drug education, Fulton (1972) observed, "We have become so convinced of the nobility of our objectives that we easily rationalize our deceit and dishonesty" (p. 33).

Educational and ethical questions arise in direct relation to the intention to manipulate attitudes and behaviors. "At question is the issue of whether we regard the educational process as a means of teaching one how to learn - to search for truth - or as a means of controlling behavior (psychologists might call this 'shaping')" (Fulton, 1972, p. 33). Several prominent writers have directly stated their intent to shape or condition behaviors. Others have been less direct even though their meaning and procedures are similar. Carney's (1971c) research on the Coronado program found, "the values oriented approach . . . has lead to one of the major breakthroughs in . . . the shaping [emphasis added] of more productive attitudes and behaviors" (p. 120). Similarly, Swisher and Piniuk (1975) referred to the "systematic shaping" of attitudes to create "healthy" attitudes toward non-sanctioned drug use. In their desire to manipulate attitudes and behaviors, scientists have applied or recommended behavior modification techniques in ways that must be questioned under prevailing ethical codes. For instance, several studies (Swisher, Warner, & Herr, 1972;

Swisher, Warner, Spence, & Upcraft, 1973; Warner, Swisher, & Horan, 1973) attempted to create anti-drug use attitudes by applying principles of reinforcement theory. Group leaders in these studies attempted to "use subtle verbal and nonverbal reinforcements to student-initiated statements reflecting an unwillingness to use drugs" (Swisher, 1974, p. 151). Supposedly, the participating students were informed that they could withdraw from the group at any time, although this was not clear in the original reports. They were also informed that the intent of the program was to "encourage healthy attitudes towards drugs and to encourage participation in alteratives" (Swisher, 1974, p. 151). There was no indication that the students were aware that "healthy attitudes towards drugs" meant anti-drug use attitudes,[2] nor aware of the covert procedures being used. The question that arises is "To what extent can we accept the manipulation of a person's attitude (or behavior) by means of which they are unaware for purposes to which they have not agreed" (Brown, 1976, p. 21). Ethical codes for counselling psychology and human experimentation would question these practices under principles relating to informed consent, deception, and/or manipulation. Warner and Warner (1975) have

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[2] One of the authors in another article (Swisher & Abrams, 1974) admitted to the arbitrariness in meaning of terms such as "healthy."

similarly discussed ethical problems in the application of behavioral modification techniques in drug education. Whenever the intent of a program is to manipulate behavior (or attitude) surreptitiously, the question of ethical violation must arise.

The intent to create compliant attitudes and behaviors by biasing the educational process is commonplace. Richard Nixon (former President of the United States) stated, "There is no priority higher in this administration than to see that children and the public learn the facts about drugs in the right way and for the right purposes" (Nixon, 1971, p. 1). Are we to believe the "facts" can be presented in the "right" way in order to achieve the "right" result--without introducing bias or compromising honesty? Often, sincere concerns about the very real problems associated with non-medical drug use have led to statements which appear to promote expediency over honesty. A statement from the Coronado Plan research recommended, "educational or other efforts should be directed to increasing perception of risk and decreasing perception of gain from 'undesirable' (depriving) behaviors in contrast to 'desirable' (enhancing) behaviors" (Carney, 1970b, p. 6). The author did not suggest making perceptions more accurate or representative but rather than perceptions should be manipulated for creating compliant behaviors. In a similar vein, the New York legislative committee (Betros, 1974) appears to have rejected accuracy and honesty in drug education since it is "neutral" and

"therefore cannot specifically deter chemical substance abuse" (p. 9). In reflecting on the current reluctance to include information in drug education for fears that it might encourage non-sanctioned drug use--one might be tempted to wonder if the withholding of information might be an attempt to mislead by letting students believe that non-sanctioned drug use is more dangerous than can be demonstrated.

Sometimes the intent to bias the educational process is obscurred by a sophisticated-sounding vocabulary. A recent study examined the manipulation of "fact valence" on attitudes towards fictitious drugs (Halliday, 1976). Experimental subjects were given fact presentations that were all negative, half negative and half positive, or all positive. As expected, anti-drug use attitudes were associated with the "negative valence" presentation and pro-drug attitudes were associated with the "positive valence" presentation. Implications for drug education suggested a strategy whereby attitudes could be predetermined by adjusting the relative proportion of positive and negative facts to which the learner is exposed. "The question that arises is . . . how much can we juggle the relative proportion of positive and negative aspects of drug use before the bias introduced compromises honesty" (Brown, 1976, p. 21).

Another writer (McGuire, 1974) has recommended a "communication-persuasion" model for manipulating the learner. This model

has been derived from research in social-psychology. According to this model, persuasive impact is governed by five major factors. These are source (the person or persons to which the message is attributed), message (characteristics and presentation), medium (through which the message is transmitted), recipient (of the message), and destination (effect intended). For example, the message transmitter has persuasive impact if the recipient perceives that the transmitter is knowledgeable and trustworthy (that is credible). The author suggests attempting to determine who the target population will regard as expert and trustworthy. Hidden beneath this recommendation is an assumption. Since the intent of the message is predetermined (that is, anti-drug use attitudes and behaviors), the credible person must also be selected for their support of the intended outcome. It would not be acceptable to select a credible person who would convey the wrong message regardless of its accuracy. Some considerations under the message factor include: what is included and what is left out, whether opposition arguments are ignored or refuted, what order the preferred and non-preferred positions are presented, whether to over or underestimate the dangers, and whether to use positive or negative appeals. All of these considerations are offered to "persuade" the learner to the predetermined attitudes and behaviors. It is to be noted that concern is not for accurate and honest presentation, nor for meaningful intellectual involvement, but rather for whatever

presentation form will ensure the desired outcome. (A case of ends justifying the means?) Similar analyses may be made regarding other recommendations made under the communications-persuasion model.

The foregoing examples and discussion have introduced concerns regarding educational integrity and ethical responsibility in the current drug education literature. Without prejudice to the authors named, nor with intent to question their motivations, the types of manipulations recommended are seen as inconsistent with generally accepted educational procedure and ethical responsibility. Whenever attempts are made to control attitudes or behaviors by covert means, whether by conditioning, selective presentation of information, or communication manipulation, these issues must arise.

Conclusion

A number of other important issues may be identified which raise concerns regarding the acceptability of current drug education trends. Time does not permit examining these. The interested person is directed elsewhere (see Brown, 1977). On its present course, drug education may be on a collision course with mainstream education. Recommendations continue to be made for biasing the educational process and denying meaningful intellectual involvement in order that there will be no mistake that students will get the right message. It is interesting to note that behind

all drug education activity there is the assumption that society's values and rules regarding non-medical drug use are fair and reasonable. Yet, there has been an obvious concern that the young might not realize this if given the opportunity for meaningful intellectual and questioning examination. If, indeed, society's values and rules are fair and reasonable, meaningful intellectual examination should present no threat.

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